account#_____

grand PEARL
SKIN BEAUTY BODY

Patient Information Form- *please print*

Patient Name _____ Date of Birth _____age_____

Address _____ Home phone _____

City _____ State _____Zip _____ Cell Phone _____

Email address _____ Marital status M S W D Gender M F

Would you like to receive information regarding our product specials, educational seminars and events?
Yes No

Employer_____ Phone _____

May we contact you at work? Yes No Social Security #_____

If under 18:

Mother/Legal guardian Name_____ Phone _____

Address_____

Father Name_____ Phone _____

Address_____

How did you hear about our office? _____

Next of Kin/ Emergency Contact _____ Phone_____

Please indicate if there is anything we need to know to provide you more personal care_____

_____

I realize that skin care is cosmetic and not covered by insurance. I am aware that I am responsible for all charges.

_____ _____
(patient/parent/guardian signature) *(date)*

_____ _____
(witness signature) *(date)*

☐ **I Have Received a Copy of the the Notice of Privacy Practices at Grand Pearl**

acct #_____

grand PEARL
SKIN BEAUTY BODY

Skin Evaluation

Have you had previous skin treatments? Yes No

What are you interested in?
(please check all that apply):

Skin Care Treatments _____
Skin Care Products _____
Make-up _____
Laser Skin Renewal _____
Botox _____
Filler _____
Surgery _____
Longer Eyelashes _____
Hair Removal _____
Micro Needling _____
Platelet Rich Plasma(PRP) _____
Diva _____
Tattoo Removal _____

What are your main concerns?
(please check all that apply):

Sun Damage/Age Spots _____
Aged Skin _____
Texture _____
Wrinkles _____
Uneven Skin Tone _____
Acne _____
Large Pores/Blackheads _____
Oily Skin _____
Dry Skin _____
Unwanted Hair _____

Ethnicity:

Asian _____
Black _____
Caucasian _____
Hispanic _____
Mediterranean _____
Middle Eastern _____

Health History- ***check if you:***

Have Used Accutane _____
Had Gold Injections _____
Are Pregnant _____
Are Lactating _____
Are Prone to Cold Sores ____
Chemotherapy _____
Kidney Disease _____
Cancer _____
Keloid scars _____

Bleeding Disorder _____
Platelet Disorder _____
Hepatitis _____
HIV _____
Seizures ____
Hirsutism _____
Polycystic Ovarian Disease ____
Lupus, Vitiligo, Scleroderma _____
Steroid or Hormone Therapy _____

Thyroid Hormone Deficiency _____
Diabetes _____
Hypertension _____
Heart Disease _____
Currently have any active Infections _____
Have an auto immune Disorder _____

Allergies/Skin Sensivities:_____

Current Medications(including blood thinners, supplements, and any topical medications):_____

_____

Pigmentation/Hormones:

Do you have regular periods? Yes No
Are you going through menopause? Yes No
Did you get hyperpigmentation (pregnancy mask) during pregnancy? Yes No

Do you have:

Broken Capillaries _____
Rosacea _____
Redness _____

Sun Exposure:

Do you wear sunblock? Yes No
Have you had skin cancer? Yes No
When was your last sun exposure? _____
Do you use self-tanning lotion? No Yes (when?_____)

When in the sun without protection, do you *(circle all that apply):*

always burn • sometimes burn • never tan • sometimes tan • eventually tan • always tan

_____ _____ _____

(patient print name) *(patient signature)* *(date)*